Supreme Court, U.S.
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No.

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1994

DEL CRANE MEDICAL CORPORATION,
Plaintiff and Appellant,

VS.

DEPARTMENT OF HEALTH SERVICES,
Defendant and Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF THE UNITED STATES

JOHN D. HARWELL
(State Bar #84813)
225 27th Street
Manhattan Beach, CA 90266
(310) 546-7078
Counsel of Record

Bowne of Los Angeles, Inc., Law Printers (213) 627-2200

QUESTIONS PRESENTED

1. Whether the California Medi-Cal rules prohibiting out-of-state providers can be permitted to supersede federal Medicare rules which oblige Medi-Cal to pay a mandatory 20% co-payment to all providers of Medicare supplies on behalf of qualified beneficiaries, without regard to the location of the provider.

2. Whether the Supremacy or Commerce Clauses of the federal Constitution prohibit California's prohibition of out-of-state providers for federally funded healthcare programs.

LIST OF PARTIES AND RULE 29.1 LIST

The parties to the proceedings below were Petitioner Del Crane Medical Corporation and Respondent California Department of Health Services. Del Crane Medical Corporation is an Ohio corporation. Del Crane Medical Corporation has no parent or subsidiaries.

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Defendant and Respondent.

PETITION FOR A WRIT OF CERTIORARI

Petitioner Del Crane Medical Corporation respectfully pray that a Writ of Certiorari issue to review the judgment and opinion of the Supreme Court of California entered in the above-entitled proceeding on September 21, 1994.

OPINIONS BELOW

The opinion of the Supreme Court was not reported and is reprinted in the appendix hereto as Exhibit A.

The opinion of the California Court of Appeal (Third Appellate District) was not certified for publication. It is reprinted in the appendix hereto as Exhibit B.

JURISDICTION

The California Court of Appeal entered its decision on June 29, 1994. On September 21, 1994, the California Supreme Court denied review of that decision. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257.

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

The Supremacy Clause of the federal Constitution, Art. VI, Sec. 5, Cl. 2 ("This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."); the Commerce Clause of the federal Constitution, Art. I, Sec. 8, Cl. 3 ("To regulate commerce with foreign nations, and among the several States, and with the Indian tribes."); 42 U.S.C. § 1396a(a)(10) ("[a] State plan for medical assistance [Medicaid] must . . . provide,") 42 U.S.C. 1396a(a)(10)(E), "for making medical assistance [Medicaid] available for Medicare cost-sharing (as defined in section 1396(p)(3) of this title) for qualified Medicare beneficiaries described in section 1396d(p)(1)...."

STATEMENT OF THE CASE

Petitioner, Del Crane Medical Corporation ("Del Crane") seeks this Writ of Certiorari to review a decision by the California State Courts which upheld the administrative decision made by Respondent which bars Del Crane, a nationwide provider of supplies to Medicare-eligible patients, from doing business in California. Del Crane's petition for a writ of mandate sought to compel the Department of Health Services ("DHS") to comply with federal and California law, implement and enforce it's own regulations and properly reimburse suppliers to California residents who are eligible for Medicare Part B payments in the manner provided by law. Del Crane did not seek to create new regulatory procedure, but rather seeks to enforce that which has existed, but not consistently been followed, since 1988.

I. THE REGULATORY FRAMEWORK

This case involves the federal healthcare reimbursement programs generally referred to as Medicare and Medicaid (Medi-Cal in California). The regulatory framework for these two elements of the Social Security system is complex almost beyond description. Fortunately for this Court and the litigants, this case involves a very narrow portion of this program.

A. Medicare Part A and Medicare Part B.

Under the Medicare Act, the federal government provides people who are 65 years of age and older and certain disabled individuals with an inpatient hospital insurance plan known as "Part A". *42 U.S.C.* §§ *1395c-1395i-4*. The Medicare Act also provides that people who are Medicare-eligible may voluntarily obtain supplementary insurance for other medical care, including certain physician services, hospital outpatient services, supplies and other health services generally not covered under Part A. *42 U.S.C.* §§ *1395j-1395w-4(j)*. This coverage is known as "Part B" and is the part of the Medicare statute involved in this matter. To obtain this coverage, a Medicare-eligible person must pay insurance premiums. Once Part B coverage is obtained, the federal government pays 80% of the "reasonable charges" (as that term is defined in the statute) incurred by the beneficiary. Medicare patients themselves are responsible for paying the remaining "coinsurance" (as defined) amount (the remaining 20%) and an annual deductible.

The Medicaid Act, a statute separate from the Medicare Act, provides for a joint federal and state funded system which subsidizes medical care for the needy, regardless of age. California, through Medi-Cal (administered by respondent DHS) is a participant in the Medicaid program.

B. The Federal Program Mandates States' Payment Of Medicare Co-Insurance and Deductible Payments.

Recognizing that Medicare eligible patients may also be needy and not able to pay their own coinsurance and deductible, or even the Part B premiums, the Medicare Act provides, in *42 U.S.C. Section 1395v* that states pay the Part B premiums on behalf of such poor elderly. Similarly, a group of elderly known as "qualified Medicare beneficiaries" ("QMBs") have been provided for in the Medicare Act and are provided with Part B coverage through a buy-in agreement funded by the states. *42 U.S.C. § 1396d(p)(3)*.

This cost sharing in the provision of Part B coverage is mandated in the Medicare Act which provides "[a] State plan for medical assistance [Medicaid] must . . . provide,"[1] *42 U.S.C. 1396a(a)(10)*, "for making medical assistance [Medicaid] available for Medicare cost-sharing (as defined in section 1396(p)(3) of this title) for qualified Medicare beneficiaries described in section 1396d(p)(1)...." *Id. at § 1396a(a)(10)(E)*. Cost sharing is defined as Part B premiums, deductibles and the difference between the amount paid by Medicare (80%) and the "amount that would have been paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent' [*i.e.*, 20% plus any deductible payments]." *Id. at 1396d(p)(3)*.

California's Medi-Cal program has enacted regulations to implement this cost sharing program in *Title 22, California Code of Regulations, § 50258*, which reads in part:

> "(c) Benefits: The Department [DHS] shall pay: Medicare premiums, coinsurance [the 20% not paid by

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[1] All bracketed material in quotations within this Petition has been added.

Medicare], and deductibles for qualified Medicare beneficiaries. . . ."

This regulation was adopted as an emergency matter and operative August 13, 1990.

II. FACTS

Del Crane is an Ohio based supplier of Part B reimbursable supplies to Medicare beneficiaries located in some 32 states, including California. Although Del Crane is qualified to do business in California, it in fact technically does no business in California, as it has no offices or employees in the State. Rather, Del Crane receives orders for supplies needed by Medicare beneficiaries, ships the supplies to the beneficiary and takes an assignment of the beneficiaries right to receive reimbursement from Medicare.[2] Del Crane looks to the beneficiary or to the state Medicaid programs for payment of the 20% coinsurance and annual deductible.

Although Del Crane does not supply goods or services to Medi-Cal patients who are not primarily Medicare Part B patients (and thus Medi-Cal is only the payor for coinsurance and deductibles), Del Crane has had for many years a provider number issued by DHS which permitted Del Crane to submit claims for reimbursement to Medi-Cal for the statutory portion of charges not paid by Medicare Part B. On May 18, 1990, DHS, through Michael Lynskey, Chief of the Provider Master File Unit, notified Del Crane that its

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[2] The procedure of "assignment" is the method of reimbursement favored by Medicare. A Medicare provider, whether a physician or other supplier, taking "assignment" submits claims on behalf of the beneficiary and, save for the 20% mandatory coinsurance payments and deductible payments, agrees not to bill the patient for any excess amount, irrespective of the actual cost of services or supplies provided. Medicare provides a certain reimbursement enticement to encourage providers to be "participating" providers.

provider number was deactivated as part of an effort to establish the *bona fides* of out-of-state providers. On or about June 1, 1990, DHS reinstated Del Crane's provider number after receiving information that demonstrated that Del Crane was a licensed Ohio organization.

On July 26, 1991, retroactive to June 1, 1990, DHS again deactivated Del Crane's provider number and ceased payment of claims received as of July 26, 1991. The stated reason for this deactivation was that Del Crane was not located within the State of California.

The DHS advised Del Crane that it could be reinstated as a provider if it opened an office in California or relocated it's business there. Federal law, however, prohibits Del Crane from billing to a California-based Medicare carrier, as the rules regarding such billing oblige Del Crane to bill South Carolina, because Del Crane's "main office" is located east of the Mississippi.[3] Accordingly, since July 27, 1991, Del Crane has continued to provide Medicare Part B benefits to California residents without receiving reimbursement for the 20% coinsurance or annual deductible amounts.

REASONS FOR GRANTING THE WRIT

I

The DHS is Violating Both Federal And State Law In Refusing To Reimburse Del Crane As Provided For Under Law.

As is shown in the preceding discussion of the regulatory scheme, the DHS is obliged to compensate the Medicare beneficiary (and thus Del Crane as it is accepting assign-

[3] The rules regarding the claims filing requirements of Medicare are complex and lengthy. For the purposes of this matter it is only important to know that Del Crane could not follow federal law and bill a California carrier, as the DHS wants, without moving its entire business from Ohio.

ment) for the 20% difference between what is paid by Medicare and what is an allowable cost, as well as for that portion of the beneficiary's annual deductible which is involved in the transaction. Although an earlier case in the federal courts of California seemed to suggest otherwise (*Samuel v. California Dep't of Health Services*, 570 F.Supp 566 (N.D. Cal. 1983)), there should now be no doubt, following the amendments to the Medicare Act and the promulgation of the California Regulation, that these payments are simply due.

The Medicare program is designed with the intent that "providers who furnish medical care to Medicare-eligible patients have the right to collect 100% of their reasonable costs or charges." *See New York City Health And Hospitals Corporation v. Perales*, 954 F.2d 854 (2d Cir, 1992) (Cert. Den., 113 S.Ct. 461) (hereinafter "*Perales*"). The *Perales* court had before it questions very similar to those before this Court and Petitioner respectfully commends this Court to that decision for a full explanation (impracticable here because of the length of that decision) of the considerations and legislative history of the changes that make payment by California mandatory.

Respondent Department of Health Services ("DHS") argues that Medicare patients who have co-payments and deductibles paid, pursuant to federal law, by state Medicaid programs, including Medi-Cal, are Medicaid patients for purposes of state regulations. This argument has been considered and rejected by the only courts to squarely consider the issue. In *Perales*, the court considered this issue at length:

> "If Medicaid alone controlled with respect to dual eligible, then it would make little sense for Medicare Part B to pay 80% of the Medicare rate for crossover care. If Medicaid were in fact the controlling program, then one would expect providers to be compensated at

the Medicaid rate, instead of at 80% of the Medicare rate. Moreover, if crossovers were "primarily Medicaid patients," there would be no basis for Medicare to allow (as it does), as a hospital's bad debt expense, the uncollected Medicare cost-sharing amounts.

Beyond the face of the statute, the Senate Report accompanying the initial Medicare Act reveals that Congress sought to avoid a wealth-based, two-tiered system of health care for the elderly and certain disabled and indeed wanted to integrate all of those who were Medicare-eligible into the existing health care system. "Since the reasonable cost of the services would be covered, hospitals would not be deterred, because of nonpaying or underpaying patients in this aged group, from trying to provide the best of modern care." S. Rep. No. 404, 89th Cong., 1st Sess. 27 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1967-68. "The provision of insurance against the covered costs would encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged." S. Rep. No. 404, 89th Cong., 1st Sess. at 24, 1965 U.S.C.C.A.N. at 1965.

Deeming dual eligible and QMBs to be primarily Medicaid rather than Medicare patients prevents health care providers from collecting their reasonable costs or charges. Providers will consequently refrain from treating the most vulnerable of the elderly and disabled, those who are also poor. These groups are the true subjects of this appeal, and such a result is fundamentally at odds with Congress' vision in enacting the Medicare Act." *Perales, Supra* at 954 F. 2d 858-859.

Notwithstanding the careful efforts of the DHS to the contrary, there is simply no legislative authority for the proposition that Medi-Cal can arbitrarily establish a limit to

its responsibility under state, let alone federal requirements to make such co-payment and deductible payments to Medicare suppliers.

Del Crane does not contend that Medi-Cal ought not have authority to exert proper supervision of suppliers of diapers and other supplies to the Medi-Cal program, which seem to be provided to nursing facilities unlike the Medicare program which provides for supplies to beneficiaries (individual patients) only. This, however, is not what Del Crane wishes. It does not wish to be a supplier to Medi-Cal or any of its authorized nursing facilities. It wishes to continue to provide only to Medicare and to have the DHS fulfil its separate obligation to make co-payments on behalf of appropriate patients.

During the Samuel era, the federal law regarding state program payment of co-payments and deductibles was optional. In 1988, Congress enacted the Catastrophic Coverage Act which eliminated the optional nature of the co-payment program. See, Medicare Catastrophic Coverage Act of 1988, Section 301(a). The legislative history for this change is found in the *CCH Medicare and Medicaid Guide,* Number 557, pp. 299-303. Similarly, the DHS overlooked the fact that the California legislature enacted legislation in *direct response to the changed federal law,* to wit:

> "(c) Benefits: The Department shall pay: Medicare premiums, coinsurance and deductibles for qualified Medicare beneficiaries . . . ." *See* Title 22, California Code of Regulations, § 50258.

The *Perales* court was faced with exactly the same circumstances as face this court. The New York Medicaid program established regulations which limited the co-payment amount it would pay on behalf of Qualified Medicare Beneficiaries to the difference between the Medicaid amount and the amount already paid by Medicare and

if the Medicare amount was greater, made no payment. The *Perales* court specifically and unequivocally ruled that this violated the state program's obligations to pay co-payments and held that the state program was not in the position to second guess or re-write the federal legislation. Those same considerations apply to this case. The *Samuel* case simply is no longer good law.

II

THE STATE COURTS AND THE CIRCUITS ARE SPLIT ON THE APPLICATION OF THE LAW

Since the decision in *Perales*, three other courts have considered the same questions. In *Rehabilitation Associates of Virginia, Inc. v. Kozlowski, et al.*, (E.D., V.A. Nov. 22, 1993) 838 F.Supp. 243, the court sided with the *Perales* court. *Pennsylvania Medical Soc'y v. Snider*, 29 F.3d 886.

California law, as expressed by the Court of Appeal stands in isolation from the federal courts which have considered this question. This Court should conform the status of the law to make it applicable nationwide.

III

CALIFORNIA REGULATIONS MUST YIELD TO THE SUPREMACY OF FEDERAL LAW.

It is abundantly clear that "Principles of federalism, as well as the Supremacy Clause, dictate that . . . state law must give way to vindication of the federal right when that right is asserted in state court." *Felder v. Casey* (1988) 487 U.S. 131, 143.

Even state law enacted for what seems good and proper purposes, as Respondent argues, must fail in the face of conflicting federal law:

> "We can no longer adhere to the abberational doctrine . . . that state law may frustrate the operation of federal law as long as the state legislature in passing the law had some purpose in mind other than one of frustration. Apart from the fact that it is at odds with the approach taken in nearly all of our Supremacy Clause cases, such a doctrine would enable state legislatures to nullify nearly all unwanted federal legislation by simply publishing a legislative committee report articulating some state interest or policy — other than frustration of the federal objective — that would be tangentially furthered by the proposed state law." *Perez v. Campbell* (1971) 402 U.S. 637, 645.

Although Respondent has argued that the purposes of the regulations replied upon by them to deprive Del Crane of the Medicare co-payments and deductible amounts is in furtherance of legitimate state interests, rather than merely effecting financial savings, "The relative importance to the State of its own law is not material when there is a conflict with a valid federal law. . . . [A]ny state law, however clearly within a State's acknowledged power, which interferes with or is contrary to federal law, must yield." *Free v. Bland* (1962) 369 U.S. 663, 666.

These principals have been applied to Social Security matters[4] before. *See Townsend v. Swank* (1971) 404 U.S. 282, 286 [state eligibility standard excluding minor college students from support though eligible under social security act invalid]; *Carelson v. Remillard* (1972) 406 U.S. 598, 590 [state rule that a parent's absence because of military duty does not qualify child for assistance invalid].

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[4]Medicare and Medicaid operate within the Social Security program.

Respondent argues that its interpretation of law must be given great weight. However, as is seen in the *Perales* case, this deference to administrative interpretation falls in the face of conflicting federal law.

> "[W]here — as here — an issue is a question of law involving statutory construction and analysis of Congressional intent, and the meaning of the statute is clear, an agency interpretation is entitled to less deference. . ." *Perales, Supra* at 954 F.2d 861.

The *Perales* analysis has recently been upheld in subsequent cases. In *Luyando v. Sullivan*, 808 F. Supp. 283 (S.D. N.Y. 1992), the court held:

> "I do not defer to the Agency's interpretation because I find it to be inconsistent with Congress intent and the statutory scheme Congress enacted. I note, however, that two additional reasons counsel against deferring to the administrative interpretation in this case. First, when a dispute involves purely legal questions, rather than issues of policy, courts do not suffer from the relative lack of expertise Chevron intended to address. See *Perales, Supra* at 954 F.2d 854, 861 (where an issue is a question of law involving statutory construction and analysis of Congressional intent, and the meaning of the statute is clear, an agency interpretation is entitled to less deference). Second, deference in this case would be especially inappropriate because the Department of Health and Human Services has taken a variety of different and inconsistent positions on the availability of multiple pass-throughs under the statute. See *Wilcox v. Ives*, 864 F.2d 915, 922-26 (1st Cir. 1988). As the Perales court explained, "even where a statute is ambiguous or silent on a particular question . . . where the Secretary's policy is inconsistent with an earlier policy, that inconsistency is ground for

rejecting a claim for deference". 954 F.2d at 861." *Id.*, at 808 F. Supp 286.

Moreover, where, as in this case, the administrative agency has vacillated on the subject matter (*See* Respondent's Brief, p. 6), "that inconsistency is a ground for rejecting a claim for deference" (Id.) and "an agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is 'entitled to considerably less deference' than a consistently held agency view." *See Perales, Supra* at 954 F.2d 860; *Luyando, Supra* at 808 F. Supp. 286; *I.N.S. v. Cardoza-Fonseca* (1987) 480 U.S. 421, 446 fn. 30.

IV

THE CALIFORNIA IN STATE OFFICE REQUIREMENTS VIOLATES THE COMMERCE CLAUSE OF THE FEDERAL CONSTITUTION

Nutritional Support Services v. Miller (1993) 830 F.Supp 625 (*"Miller"*) could hardly be more similar to the factual circumstances of this case. Because of the similarities, a close comparison is appropriate.

In *Miller*, the plaintiffs were suppliers of durable medical supplies to residents of nursing homes in Georgia. *Id.*, at 830 F.Supp 626. The plaintiffs did not have offices located within the state. *Id.* Until June, 1991, Plaintiffs had received reimbursement for such supplies. *Id.* In June, 1991, the state enacted a new policy requiring all suppliers of durable medical supplies to maintain an office within the state or within a 50-mile radius of the state boundary. *Id.* As with Appellant in this case, the plaintiffs failed to meet the requirements of the state, were barred from participating in the state Medicaid program and all claims that they submitted were rejected. *Id.*, at 830 F.Supp. 626.

In the case before this court, the circumstances are identical except that the date of the bar from participation here was July, 1991 rather than June, 1991. In all other respects, the events which transpired in that case occurred in this one.

The *Miller* court considered the impact of the state's decision on the Commerce Clause, analyzing the state's contention that in instances where Congress legislates in an area, it may create an area in which the States may regulate free from Commerce Clause restraints. The court rejected this argument:

> "In the Social Security Act, Congress required that states "provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19). Further, states are allowed to set reasonable standards for the qualification of providers. 42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51(b)(c)(2). The State asserts that the purpose of the restrictions challenged in this case is to allow Defendants to exercise a degree of control over suppliers in order to enable them to protect recipients and properly allocate scarce public resources. [Citation omitted] Thus, the State argues, the regulation is authorized by 42 U.S.C. §§ 1396a(a)(19) & (23) and is invulnerable to Commerce Clause attack. [Citation omitted]
>
> The Court disagrees with the State's assertion that this case does not present a dormant commerce clause situation. As the Supreme Court's recent case law makes clear, "because of the important role the Commerce Clause plays in protecting the free flow of interstate trade, this Court has exempted state statutes

> from the implied limitations of the Clause only when the congressional direction to do so has been 'unmistakably clear.' " *Maine v. Taylor*, 477 U.S. 131, 138-39, 91 L. Ed. 2d 110, 106 S. Ct. 2440 (1986); see also *Wyoming v. Oklahoma*, 117 L. Ed. 2d 1, 112 S. Ct. 789, 802 (1992) ("Congress must manifest its unambiguous intent before a federal statute will be read to permit or to approve . . . a violation of the Commerce Clause . . ."); *Northeast Bancorp*, 472 U.S. at 174 ("When Congress so chooses, state actions which it plainly authorizes are invulnerable to constitutional attack under the Commerce Clause."). The Court concludes that the general language in the statutes in question simply does not make it "unmistakably clear" that Congress intended to allow state regulations that otherwise violate the Commerce Clause." *Miller, Supra* at 830 F.Supp 627-628.

The court considered and rejected the state's argument that any burden imposed by its policy was "incidental" and therefore not improper:

> "In its Motion for Summary Judgment, the State invokes the standard for incidental burdens on interstate commerce. [Citation omitted] The Court concludes, however, that while the policy at issue arguably may be facially neutral (i.e., both those inside the fifty mile limit and those outside the limit must have a valid business license and a business location within the fifty mile limit), at a minimum, the "practical effect" of the policy is to discriminate against providers outside of the fifty mile limit. [Citation omitted] Accordingly, the regulation is permissible only if the State carries its burden of showing both that the policy promotes a legitimate state interest and there are no less burdensome means of accomplishing this purpose." *Miller, Supra* at 830 F.Supp 628-629.

The *Miller* court assumed that the state's motive was a legitimate one, but observed "The Supreme Court, however, has noted that a state's purpose in establishing a rule is irrelevant to the Commerce Clause issue as "the evil of protectionism can reside in legislative means as well as legislative ends." *City of Philadelphia v. New Jersey*, 437 U.S. 617, 626, 57 L. Ed. 2d 475, 98 S. Ct. 2531 (1978)." *Miller, Supra* at 830 F.Supp 629.

The *Miller* court then focused on whether the state's legitimate interests could be satisfied by a means less burdensome to the Commerce Clause:

> "[T]his Court concludes that the State's policy of requiring an office within fifty miles of the state border is not the least burdensome means of reducing administrative costs and protecting Georgia citizens. By way of example, a requirement that durable medical suppliers maintain in-state (or, perhaps, within fifty miles) copies of documentation to support Medicaid claims would appear to be less burdensome and would appear to accomplish the stated purpose. Indeed, such a requirement arguably accomplishes the auditing purpose purportedly underlying the rule better than the current regulation, as the latter does not require that suppliers maintain such documentation at their in-state office. [Footnote omitted] The establishment of an in-state office, without a requirement that this office maintain records necessary for an audit by the state, would appear to further little, if any, of the regulation's purported objectives. Yet, it would appear that an in-state office without records would comply with the regulation." *Miller, Supra* at 830 F.Supp 630.

Considering the entirety of the issues raised by the state, including its claim of legitimate state interests and balancing those interests against the Commerce Clause burdens im-

posed by the policy enacted to further that interest, the *Miller* court held:

> "Because the regulation at issue discriminates against interstate commerce and is not the least burdensome means of accomplishing its stated purpose, it violates the Commerce Clause. [Footnote omitted] Accordingly, Plaintiff's Motion for Summary Judgment is granted as to their Commerce Clause claim." *Miller*, Supra at 830 F.Supp 630.

Appellant Del Crane respectfully submits that the circumstances faced by the *Miller* court is indistinguishable from those presented in this case. Del Crane was a provider of durable medical supplies to residents of nursing homes in California until July 26, 1991, when the state announced a policy of requiring all such suppliers to maintain an in-state office and terminated Del Crane's provider status for failure to do so.

Respondent has raised legitimate state interests in regulating and being able to audit providers of such supplies and Del Crane has proposed methods to accomplish such a goal without banning providers without in-state offices, going so far as to offer to defray the costs of state employees traveling to Del Crane's offices to conduct such audits. J.A. 207-208.

Appellant respectfully submits that this court should follow the reasoning of the *Miller* court and relieve the burden on the Commerce Clause created by the state's policy.

The state of California law, following the Court of Appeal decision is at odds with what must be considered the prevailing view, given the appellate status of the *Perales* decision and its subsequent support in lower court cases. The *Samuel* case is underpinned by federal statutory language which has been amended to be mandatory rather than

optional. California statutory language seems to require the payment of co-payments to Medicare suppliers.

In short, this Court of Appeal decision places Medicare suppliers in the position of having to treat California differently than other states and the entirety of the Second Circuit. This Court of Appeal decision results in the law of the land varying from place to place.

Finally, as Justice Nicholson said in his Dissent:

> "Accordingly, I find it possible and desirable to resolve this issue. There are alternatives less burdensome than the current in-state store requirements to achieve the state's goal to stem fraud and abuse in the Medi-Cal system. The current in-state store requirement is simply a misdirected overreaction to the problems caused by the state's irresponsible use of an "honor system" for Medi-Cal claims . . . Hence, Welfare and Institutions Code section 14125.8 and related statutes and regulations which require Medi-Cal providers to maintain a store within California violate the commerce clause of the United States Constitution." *Dissent,* p. 12.

Simply put, the majority admittedly "without expressing any opinion on the merits of the Department's underlying position. . . we decline to reach the issue of whether the in-store requirement violates the commerce clause." Basing this decision not to address the constitutional issue found compelling by Justice Nicholson, the majority suggested that the DHS "is entitled to make a factual record in support of its position that the challenged regulation is constitutionally possible."

Justice Nicholson, in his dissent, addressed this issue, pointing out that the DHS in supplemental briefing, asserts "Because . . . the essential facts of this case are undisputed, the record is sufficiently developed for this Court to make a decision . . . [¶] [A] remand for jury trial under Code of

Civil Procedure section 1090 is unnecessary." *See, Dissent,* at p. 12.

CONCLUSION

For the foregoing reasons, Appellant Del Crane Medical Corporation requests this Court to grant its Petition for Certiorari.

DATED: December 19, 1994

Respectfully submitted,
JOHN D. HARWELL
225 27th Street
Manhattan Beach, CA 90266
Counsel of Record

APPENDIX A

APPENDIX A

Third Appellate District No. C015672
S041304

IN THE SUPREME COURT OF THE
STATE OF CALIFORNIA

IN BANK

DEL CRANE MEDICAL CORPORATION,
Appellant
v.
DEPARTMENT OF HEALTH SERVICES,
Respondent

SUPREME COURT
FILED
September 21, 1994
Robert Wandruff, Clerk

Petition for review DENIED.

MOSK
Acting Chief Justice

APPENDIX B

APPENDIX B

NOT FOR PUBLICATION

C015672

IN THE COURT OF APPEAL
OF THE
STATE OF CALIFORNIA

THIRD APPELLATE DISTRICT
(Sacramento)

DEL CRANE MEDICAL CORPORATION,
Plaintiff and Appellant,
v.
DEPARTMENT OF HEALTH SERVICES,
Defendant and Respondent.

(Super.Ct.No. CV369756)
FILED
June 29, 1994
Court of Appeal, Third District
Robert L. Liston, Clerk

Plaintiff Del Crane Medical Corporation (Del Crane) is a provider of products to recipients under a Medicare program in which Medi-Cal pays premiums, coinsurance, and deductibles. Defendant Department of Health Services (the Department) deactivated Del Crane's provider number, thus denying it payment from Medi-Cal funds, because it violated the requirement providers must maintain a store within California. (Welf. & Inst. Code, § 14125.8.) Del Crane filed a petition for writ of administrative mandate challenging this requirement, but the trial court denied the petition. Del Crane appeals, and we shall affirm.

BACKGROUND

A. Medicare, Medicaid, and Medi-Cal

We begin with a summary of Medicare, Medicaid, and Medi-Cal programs. "Under the Medicare Act, the federal government provides people who are 65 years of age and older and certain disabled individuals (people who are Medicare-eligible) with an inpatient hospital insurance plan known as 'Part A'. 42 U.S.C. §§ 1395c-1395i-4. The Medicare Act also provides that people who are Medicare-eligible may voluntarily obtain supplementary insurance for other medical care, including certain physician services, hospital outpatient services, and other health services generally not covered under Part A. 42 U.S.C. §§ 1395j-1395w-4(j). This coverage is known as 'Part B' and is the part of the Medicare statute involved in this appeal. To obtain this coverage, a Medicare-eligible person must pay insurance premiums. Once Part B coverage is obtained, the federal government pays 80% of the 'reasonable costs' of outpatient hospital services and 80% of 'reasonable charges' for physician services rendered to the insured. Reasonable costs and charges are established pursuant to the Medicare Act and regulations. Medicare patients themselves are responsible for paying the remaining 'coinsurance' amount (20% of the reasonable costs of hospital services and 20% of the reasonable charges for physician services) and the annual deductible.

"The Medicaid Act, a statute separate from the Medicare Act, provides for a joint federal and state funded system which subsidizes medical care for the needy, regardless of age. If a state decides to participate in Medicaid, it proposes a plan which must be approved by the Secretary as conforming with federal requirements. 42 U.S.C. §§ 1396a(a), 1396a(b). The plan must include, among other things, a schedule of payment rates which the state designates for the

various kinds of medical care that a Medicaid patient might seek. Id. If the Secretary approves a state's plan, then the Federal government will assist the state in its reimbursement program with federal Medicaid funds. Those doctors and hospitals who are willing to treat Medicaid patients must agree to accept the designated Medicaid rate and not ask the patient to pay any money beyond that amount. 42 U.S.C. §§ 1320a-7b(d), formerly 42 U.S.C. § 1396h(d), and 42 C.F.R. § 447.15 (1989) . . . .

"Returning to Medicare, the authors of the statute recognized in addressing the needs of Medicare patients that the poor Medicare-eligible (those who are eligible for Medicaid as well) generally would not be able to afford to enroll in the optional Part B Medicare coverage described above, because they would not be able to pay the insurance premiums, the 20% coinsurance and the annual deductible. The Act therefore provides, in 42 U.S.C. § 1395v, as elaborated by 42 C.F.R. § 407.40-407.50 (1990), that a state may agree to pay Part B Medicare insurance premiums on behalf of such poor elderly and disabled — whom we shall call . . . 'crossovers' — and thereby acquire Part B Medicare coverage for them. By so doing, a state enrolls these crossovers in the Medicare Part B program just as less needy individuals enroll themselves when they individually choose to obtain Part B Medicare coverage and pay the insurance premiums. The federal government contributes funds to subsidize these state 'buy-in' arrangements." (*New York City Health and Hospitals v. Perales* (1992) 954 F.2d 854, 856.)

The state has the duty to administer Medicaid, including the payment of Medicare part B insurance premiums, the 20 percent coinsurance and the annual deductible. (See 42 U.S.C. §§ 1396, 1396a.) Thus, the provider must apply to the state for reimbursement of coinsurance and deductibles when it supplies a service to the Medicare part B recipient who is a crossover.

California has an approved Medicaid plan (called Medi-Cal) and enrolls those Medi-Cal recipients who are eligible in Medicare part B. (*Samuel v. California Dept. of Health Services* (1983) 570 F.Supp. 566, 569.) Thus, California administers the Medi-Cal program, which includes both straight Medi-Cal services and payment of premiums, coinsurance, and deductibles for Medicare part B crossovers. Medicare part B coverage is included in the recipient's Medi-Cal benefits, and the recipient is a Medi-Cal patient whose care is subject to California laws and regulations. (*Id.* at p. 573.)

B. The "Diaper Scam" and California Legislation

California failed to establish adequate safeguards against fraudulent Medi-Cal claims. To receive payment for claims, a provider needed only to submit a claim stating supplies had been shipped to an eligible Medi-Cal recipient. The "honor system," as the Department called it, did not work, and businesses with a propensity to commit fraud did just that. The Department refers to the fraudulent claims as the "diaper scam." Officials working under the California Attorney General estimated the fraudulent activities cost the state about $100 million in one year. (Taylor, *Diaper Scam May Be Largest Fraud in State History*, The San Francisco Chronicle (Mar. 1, 1990) p. A3.)[1]

In response to the "diaper scam," the Legislature enacted article 3.7 of chapter 7 of the Welfare and Institutions Code.

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[1]The diaper scam was reported throughout the state after the Attorney General's office raided an operation which defrauded Medi-Cal of millions of dollars. This court recently affirmed the conviction of these operators. (*People v. Boyette* (Jul. 28, 1993) C012663 [nonpub. opn.].) Arguably, it was *Boyette*, because of its wide publicity, that stimulated the Legislature to attempt to prevent fraud by enacting the in-state store requirement under consideration here. Ironically, however, *Boyette* involved a business located *within* the state, although it was operated by non-Californians.

(Welf. & Inst. Code, § 14125 et seq.) Article 3.7 regulates Medi-Cal coverage for incontinence medical supplies and restricts provider eligibility for such products. In particular, section 14125.8 requires each provider to maintain a business location in California. It requires each provider to submit to the Department "[t]he *California* driver's license or *California* identification card number of the applicants, coowners, corporate officers, and financially interested parties . . . [and] [t]he applicant's business permit control number, issued by the State Board of Equalization, for the business location where services are rendered to the public." (Welf. & Inst. Code, § 14125.8, subds. (a)(2), (a)(3), emphasis added.) In addition, Welfare and Institutions Code section 14125.2, subdivision (b), requires the provider to maintain the business location open to the public and gives the Department authority to establish rules and regulations to carry out the goals of the statutes.

The effect of these statutes and regulations is to require medical supply providers to maintain a store within California in order to receive reimbursement through Medi-Cal. The Department enforces this in-state store requirement by deactivating the Medi-Cal provider number of unqualified out-of-state providers and refusing to make payments to them.

FACTS AND PROCEDURAL HISTORY

Del Crane is an Ohio-based medical supply provider. Although it provides medical supplies to California residents, it has no store in California. Some, but not all, of the supplies Del Crane provides to California residents are incontinence medical supplies. These supplies are provided under Medicare part B, and Del Crane seeks reimbursement from the state for the coinsurance and deductibles.

Upon passage of Welfare and Institutions Code section 14125.8, the Department deactivated Del Crane's pro-

vider number, effectively preventing it from receiving Medi-Cal payment of Medicare part B coinsurance and deductibles. The Department based Del Crane's deactivation on two grounds: (1) it alleged California Code of Regulations, title 22, section 51006, renders out-of-state providers of medical care ineligible, and (2) it claimed Del Crane is a provider of incontinence medical supplies and therefore is ineligible for reimbursement under Welfare and Institutions Code section 14125.8 because it does not have a store within California.

Section 51006 of the California Code of Regulations, title 22, one of the grounds asserted by the Department, only limits medical care covered by Medi-Cal to emergencies when the patient is out-of-state. On its face, this section does not apply here because there was no allegation any of the patients to whom Del Crane provided medical supplies were outside California. It also does not apply because Del Crane provides medical products, not medical care. Thus, the only remaining ground upon which the Department can base deactivation of Del Crane's provider number is its failure to maintain an in-state store.

Del Crane petitioned the trial court for a writ of mandate directing the Department to reactivate its provider number or activate a new provider number retroactive to the date of deactivation of Del Crane's former number. Finding the Department's actions were justified by the state laws concerning out-of-state providers, the trial court entered judgment denying the petition. Del Crane appeals.

DISCUSSION

I

Legality of State Action

Del Crane claims the Department cannot deactivate its provider number because Medicare provides for payment by the State of California of coinsurance and deductibles for products and services supplied to Medicare part B crossovers. (AOB 6-8) It bases this argument entirely on a case which deals with a different issue, that is, whether a state can impose Medicaid limits on the costs for goods and services rather than paying the Medicare prices. (*Perale, supra,* 954 F.2d 854.) *Perales*, however, is contradicted by other federal cases, including one specifically dealing with California. (*Samuel, supra,* 570 F.Supp. 566.) Furthermore, *Perales* does not purport to decide the issue presented here.

In *Samuel*, the Department sought to allow providers to bill recipients for coinsurance and deductibles of Medicare part B crossover benefits, despite a federally mandated state law which prohibits seeking coinsurance and deductibles from a MediCal patient. The district court held recipients could not be billed because, even though the provider bills Medicare for 80 percent of the reasonable cost, Medicare part B benefits are included in the scope of Medi-Cal benefits and, therefore, are subject to laws concerning Medi-Cal benefits. Providers must accept Medicare part B crossovers as recipients of Medi-Cal. (570 F.Supp. at p. 573.)

Dealing with a different issue, *Perales* disagreed with *Samuel*. In *Perales*, New York sought to reduce the amount of coinsurance and deductibles it was required to pay for Medicare part B crossovers. Under the state plan, reasonable fees and costs for services and products were established for Medicaid. A provider of Medicare part B services or products would receive only the portion of the fee or cost not covered by Medicare's 80 percent payment which exceeded

the state's established Medicaid rate. For example, if the Medicare approved rate were $100 and the Medicaid approved rate were $80, Medicare would pay $80 (assuming the annual deductible had been met) and Medicaid would pay nothing. The plan also prevented the provider from collecting any money from the recipient. (*Perales, supra,* 954 F.2d at pp. 856-857.)

The *Perales* court noted providers could normally charge Medicare part B recipients who are not crossovers (that is, those who paid the premiums themselves) for the 20 percent of the reasonable cost not paid by Medicare. Therefore, it reasoned, the statutory scheme intended providers to be paid 100 percent of reasonable costs, and the state plan could not provide for less than 20 percent of the Medicare reasonable cost when a crossover received products or services. (954 F.2d at p. 858.) The court held the crossovers were not " 'primarily Medicaid patients,' " despite the prior holding of *Samuel* and an identical determination by the Secretary of the United States Department of Health and Human Services (the Secretary). (*Id.* at pp. 858-861.)

The *Perales* court stated: "Deeming [crossovers] to be primarily Medicaid rather than Medicare patients prevents health care providers from collecting their reasonable costs or charges." (954 F.2d at p. 859.) This statement, of course, assumes the Medicare rate is reasonable and the Medicaid rate is not. In addition, the court found the requirement in the federal code that state Medicaid plans make funds available for Medicare part B premiums, deductibles, and coinsurance meant the state must pay 20 percent of the reasonable cost for Medicare part B crossovers and may not reduce that payment according to a Medicaid rate. (*Id.* at p. 859, citing 42 U.S.C. 1396a(a)(10)(E).) It came to this conclusion even though a later provision permits, not requires, state payments to exceed the Medicaid amount. (*Ibid.*, citing 42 U.S.C. § 1396a(n).)

The *Perales* majority rejected *Samuel* by simply disagreeing on whether Congress intended to protect providers by guaranteeing them 100 percent payment of the costs and charges deemed reasonable under Medicare. It reasoned: "[T]he Senate Report accompanying the Medicare Act evidenced an intent to provide quality medical care for the elderly by compensating providers reasonably for their care. A guarantee of reimbursement, by protecting providers, protects patients." (954 F.2d at p. 861.)

In dissent, Justice Cardamone agreed with *Samuel* and the Secretary that crossovers are primarily Medicaid patients and criticized the majority for concluding otherwise with no supportive reasoning. (*Perales, supra*, 954 F.2d at p. 863, dis. opn. of Cardamone, J.) He argued the Secretary's position was entitled to deference and chided the majority for failing to consider the entire legislative history of Medicare and Medicaid, instead of considering only the portion that supported the desired result. (*Id.* at pp. 863-867.)

Since *Perales* was decided, courts have remained split on the issue of whether crossovers are primarily Medicare or Medicaid recipients. A federal district court in Alabama rejected the reasoning of the *Perales* majority, stating: "The Court finds it difficult to understand, particularly in the face of Congressional silence, why the states must swallow the portion of provider costs to poor Medicare recipients that exceed the 80% mandated by Congress. It is logical acrobatics to determine that Congress 'unambiguously' decreed that government would pay 100 percent of such costs to providers for [crossovers] simply because Congress provided that government pay 80 percent of reasonable provider costs for Medicare beneficiaries with the right given to the provider to collect the remaining 20 percent from the supplemental insurance paid for by the Medicare beneficiary who is able

to pay for such insurance." (*Haynes Ambulance Service v. State of Ala.* (1993) 820 F.Supp. 590, 593.)

The *Haynes* court held the Secretary's determination, manifest by her approval of Alabama's state plan, deserved recognition because there was no contradictory intent manifest in the legislation. (820 F.Supp. at pp. 593-595.) It concluded: "Courts should not, at the instance of providers, construe Congressional silence to require states to shoulder added medical costs which neither the states, nor the federal agency charged with administering the federal statutes, believe are compelled by Congress." (*Id.* at p. 596.)

A federal district court in Virginia disagreed with the *Perales* dissent and *Haynes* and adopted the reasoning of the *Perales* majority without substantial elaboration. (*Rehabilitation Ass'n of Virginia, Inc. v. Koslowski* (E.D.Va. 1993) 838 F.Supp. 243.) Accordingly, there is a continuing split in authority concerning whether a state must pay the full deductibles and 20 percent coinsurance for crossovers, even when the amount exceeds the cost determined by the state for the service and approved by the Secretary.

The issue at hand is different. In the cases thus far cited, there was no issue concerning whether the states had the authority to regulate the companies providing benefits to crossovers under Medicare part B. While the practical effect may be the same, that is, the payment of coinsurance and deductibles by the state to the provider on behalf of crossovers is subject to the state Medicaid plan, the issue here is whether the state can regulate the providers or must simply pay the coinsurance and deductibles, no questions asked.

Del Crane suggests the regulation at issue violates both federal and state law, contending coinsurance and deductibles are "simply due." There is no discussion or authority for the assertion the regulation violates state law; accordingly, it is waived. Concerning federal law, Del Crane

merely cites *Perales* and "commends this Court to that decision for a full explanation (impracticable here because of the length of that decision)...."

This argument is completely inadequate. Other than its citation of *Perales,* Del Crane makes no attempt to argue the state cannot regulate providers of Medicare part B services and products to crossovers. We see nothing to suggest that is the case. To the contrary, the state's plan, approved by the Secretary, provides for regulation of those providers, and Del Crane offers no argument state regulation conflicts with federal regulation. Indeed, Medicare and Medicaid are designed to coexist. Common sense dictates government must take responsibility for the funds it expends on social programs.

That state regulation has the effect of denying 100 percent payment of the Medicare "reasonable cost" is irrelevant, especially since Del Crane does not allege it would not receive 100 percent if it were to comply with state regulations. In arguing below, Del Crane tacitly conceded the state has the authority to regulate providers of Medicare part B services and products to crossovers when it offered to agree to audits, inspections, and supervision by the Department. In sum, Del Crane fails to make any argument against state regulation over its provision of products to crossovers. Furthermore, except for a belated constitutional argument which we shall also reject, Del Crane fails to assert the regulations, which we characterize generally as an in-state store requirement, are unlawful.

Trying another method of attacking the trial court's determination, Del Crane claims there is no statutory authority for the action taken by the Department in deactivating its provider number. This argument is based on the premise, not even stated in the opening brief, that Del Crane is not a provider of incontinence medical supplies. In response, the Department asserts the statutory authority, as

related above, to require out-of-state providers to maintain a store within California. Del Crane replies by baldly denying it provides diapers or incontinence pads, but deftly avoiding an admission it provides other types of incontinence medical supplies.

We requested supplemental briefing concerning whether Del Crane is a supplier of incontinence medical supplies. In its supplemental brief, Del Crane admits it does provide some incontinence medical supplies to Medicare part B recipients in California. It does not explain, however, why this fact does not make it subject to California's regulations concerning providers of Medicare part B products and services, including the in-state store requirement. As stated above, apart from the question debated in *Samuel, Perales,* and other cases determining whether states can limit the amount of coinsurance and deductibles paid on behalf of crossovers to Medicare part B providers, the question of California's authority to regulate such providers is not discussed by Del Crane.

Del Crane is a provider of incontinence medical supplies seeking to receive payments from Medi-Cal funds, and California has regulations, as reviewed above, concerning such providers. Del Crane's contention there was no authority for the state to deactivate the Medi-Cal provider number is without merit.

Finally, Del Crane asserts the trial court erred by upholding the deactivation under section 51006 of title 22 of the California Code of Regulations which applies only to medical care rendered out-of-state. We agree section 51006 is inapplicable. However, we review the ruling, not the reasoning (*City of National City v. Wiener* (1992) 3 Cal.4th 832, 850), and the ruling is supported by Del Crane's violation of the in-state store requirement.

II

Tardy Assertion of the Commerce Clause Issue

Del Crane raises for the first time in its reply brief the issue of whether the in-state store requirement violates the commerce clause. We have discretion to refuse to consider a point raised for the first time in the reply brief. (9 Witkin, Cal. Procedure (3d ed. 1985) Appeal, § 496, pp. 484-485.) "Obvious considerations of fairness in argument demand that the appellant present all of his points in the opening brief. To withhold a point until the closing brief would deprive the respondent of his opportunity to answer it or require the effort and delay of an additional brief by permission. Hence, the rule is that *points raised in the reply brief for the first time will not be considered,* unless good reason is shown for failure to present them before." (*Ibid.*, emphasis in original.)

Del Crane claims we should consider the issue for the following reasons: (1) it would resolve finally all issues between the parties; (2) there were new developments in the case law during the pendency of the appeal; (3) this court is free to consider any issue; and (4) our request for supplemental briefs on the constitutional issue satisfies any fairness concerns. (1st ASB 3-6) Only the second reason, that is, new developments in the law, even attempts to show good cause for the failure to raise the constitutional issue in a timely manner. The remainder are simply matters we take into consideration when exercising our discretion.

On August 20, 1993, after Del Crane filed its opening brief, a federal district court in Georgia issued *Nutritional Support Services, L.P. v. Miller* (N.D.Ga. 1993) 830 F.Supp. 625 (hereafter *Nutritional Support*), in which it struck down a state regulation requiring Medicaid providers to maintain an office within the state or within a 50-mile radius of the state. It held the regulation violated the

commerce clause because it discriminated against interstate commerce and was not the least burdensome means of accomplishing its purpose. (*Id.* at p. 629.)

While it may have been the first case to relate the commerce clause to a Medicaid in-state office requirement, *Nutritional Support* relied on cases holding in-state office requirements generally violate the commerce clause. (830 F.Supp. at p. 628.) Since *Nutritional Support* was merely a specific application of well-founded principles, Del Crane should have raised the issue below and in its opening brief based on those principles. The filing of *Nutritional Support* does not provide good cause. As the Department pointed out in its letter brief, reaching the commerce clause issue in this posture would be particularly inappropriate because factual questions remain to be adjudicated. "Critical to a determination of whether the challenged in-state office requirement violates the commerce clause of the United States Constitution is an assessment of whether the state could have furthered the legitimate policy goals embodied in the statute through alternative means, ones that would be less burdensome on commerce. Resolution of this issue requires the development and analysis of a fairly substantial set of facts involving, for instance, an assessment of the precise nature and scope of the operational burden, if any, the requirement imposed on [Del Crane], the types of alternative fraud prevention and financial reporting procedures available to [the Department] and whether there were any practical, operational or policy barriers to their adoption and implementation by [the Department]." Without expressing any opinion on the merits of the Department's underlying position, we agree that it is entitled to make a factual record in support of its position that the challenged regulation is constitutionally permissible. Accordingly, we decline to reach the issue of whether the in-state store requirement violates the commerce clause.

DISPOSITION

The judgment is affirmed.

SPARKS,
Acting P.J.

I concur:

SIMS, J.

I respectfully dissent.

Although I agree with the majority's treatment of the issues raised in a timely manner, I would reverse based on Del Crane's delayed assertion the in-state store requirement violates the commerce clause. We requested and received supplemental briefing on this issue. Having provided the department with the opportunity to respond, I would exercise discretion in favor of considering it. Indeed, the mere presence of an in-state store requirement is suspect and demands a determination of its validity under the commerce clause. Del Crane should have recognized this problem much earlier in the litigation. Nonetheless, it has now raised the issue, and the department has responded in supplemental briefing.

I

Violation of the Commerce Clause

"The Commerce Clause of the United States Constitution provides that '[t]he Congress shall have Power . . . [t]o regulate Commerce . . . among the several States . . . Art I, § 8, cl 3. It is long-established that, while a literal reading evinces a grant of power to Congress, the Commerce Clause also directly limits power of the States to discriminate against interstate commerce. [Citations.] 'This "negative"

aspect of the Commerce Clause prohibits economic protectionism — that is, regulatory measures designed to benefit in-state economic interests by burdening out-of-state competitors.' [Citations.] When a state statute clearly discriminates against interstate commerce, it will be struck down (citation] unless the discrimination is demonstrably justified by a valid factor unrelated to economic protectionism [citation]. Indeed, when the state statute amounts to simple economic protectionism, a 'virtually per se rule of invalidity' has applied." (*Wyoming v. Oklahoma* (1992) 502 U.S. ____, ____ [117 L.Ed.2d 1, 22].)

"[O]nce a state law is shown to discriminate against interstate commerce either on its face or in practical effect, the burden falls on the State to demonstrate both that the statute serves a legitimate local purpose, and that this purpose could not be served as well by available nondiscriminatory means." (*Maine v. Taylor* (1986) 477 U.S. 131, 138 [91 L.Ed.2d 110, 121], citations and quotation marks omitted.) "It is well established that Congress may authorize the States to engage in regulation that the Commerce Clause would otherwise forbid. But because of the important role the Commerce Clause plays in protecting the free flow of interstate trade, [the United States Supreme Court] has exempted state statutes from the implied limitations of the Clause only when the congressional direction to do so has been unmistakably clear." (*Id.* at pp. 138-139 [91 L.Ed.2d at p. 121], citations and quotation marks omitted.)

A. Federal Precedent

A federal court in Georgia recently struck down a similar in-state office requirement because it violated the commerce clause. (*Nutritional Support Services, L.P. v. Miller* (1993) 830 F.Supp. 625 (*Nutritional Support*).) The court concluded the regulation discriminated against interstate com-

merce and was not the least burdensome means of accomplishing the purpose of the regulation. (*Id.* at p. 629.)

The specific regulation at issue in *Nutritional Support* was a requirement that all Medicaid providers of durable medical supplies to residents in Georgia have a business location within the state or within 50 miles of the state boundaries. (*Nutritional Support*, *supra*, 830 F.Supp. at p. 626.) Georgia asserted the purpose of the regulation was to allow the state to exercise control over the providers and protect state residents while properly allocating scarce state resources. (*Id.* at 627.)

Georgia contended Congress authorizes the states to exercise this type of control over providers. In support, it cited the Medicaid provisions of the federal Social Security Act. (*Nutritional Support*, *supra*, 830 F.Supp. at p. 627.) "A State plan for medical assistance must . . . provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients . . . ". (42 U.S.C. § 1396a(a)(19).) The state must also assure the care and services provided are of high quality. (42 U.S.C. § 1396a(a)(22) & (23).) The court, however, rejected the notion these statutes make it "unmistakably clear" Congress intended to authorize the states to discriminate against interstate commerce. (*Nutritional Support*, *supra*, 830 F.Supp. at p. 628.)

The court found the in-state office requirement to discriminate against interstate commerce in practical effect, if not on its face, and applied the test to determine whether the regulation serves a legitimate purpose which could not be served by less burdensome means. (*Nutritional Support*, *supra*, 830 F.Supp. at p. 628, relying on *Maine v. Taylor*, *supra*, 477 U.S. at p. 138 [91 L.Ed.2d at pp. 120-121].) It assumed the regulation's purpose was legitimate, but found

there were less burdensome means for achieving the purpose. (*Nutritional Support, supra,* at p. 629.)

The *Nutritional Support* court concluded: "[Georgia's] policy of requiring an office within fifty miles of the state border is not the least burdensome means of reducing administrative costs and protecting Georgia citizens. By way of example, a requirement that durable medical suppliers maintain in-state (or, perhaps, within fifty miles) copies of documentation to support Medicaid claims would appear to be less burdensome and would appear to accomplish the stated purpose. Indeed, such a requirement arguably accomplishes the auditing purpose purportedly underlying the rule better than the current regulation, as the latter does not require that suppliers maintain such documentation at their in-state office. The establishment of an in-state office, without a requirement that this office maintain records necessary for an audit by the state, would appear to further little, if any, of the regulation's purported objectives. Yet, it would appear that an in-state office without records would comply with the regulation." (830 F.Supp. at p. 629.)

Other federal district courts have also held in-state office requirements violate the commerce clause because the purposes of the requirements could be achieved by means less burdensome. (See *Ga. Ass'n of Realtors v. Ala. Real Estate Com'n* (1990) 748 F.Supp. 1487, 1492-1495; *Underhill Assoc., Inc. v. Coleman* (1981) 504 F.Supp. 1147, 1150-1152.) In the Georgia realtors case, the court discussed a United States Supreme Court case not directly on point but containing helpful analysis: "[I]n *Frazier v. Heebe*, 482 U.S. 641, 107 S.Ct. 2607, 96 L.Ed.2d 557 (1987), the Supreme Court [considered] a rule of a federal district court which required a continuous in-state residence or maintenance of an in-state law office for eligibility to practice law in the district court. The Supreme Court, pursuant to its supervisory authority over federal district courts, held

that the district court was not empowered to require members of the state bar to also maintain an in-state office. The Supreme Court found such a requirement to be unnecessary and irrational., The Supreme Court was not considering such a requirement under the Commerce Clause, but its language that such a requirement for lawyers is 'unnecessary and irrational' suggests that such requirement for realtors is similarly lacking in rationality. In performing the balancing test to determine whether the burden on interstate commerce is excessive in relation to the putative local benefit, it is difficult to adequately justify such a burden where the requirement has been characterized by the Supreme Court as both unnecessary and irrational." (*Ga. Ass'n of Realtors, supra,* at p. 1494, fn. 2.) In-state office requirements are "extremely burdensome." (*Underhill Assoc., Inc., supra*, at p. 1152.)

B. *The Department's Arguments*

The department argues the in-state store requirement of Welfare and Institutions Code section 14125.8 does not violate the commerce clause because (1) Congress has authorized regulations to administer Medicaid benefits, (2) the state is acting as a market participant, not a market regulator, and (3) the Legislature did not enact the requirement as economic protectionism.

1. *Congressional Authorization*

Disagreeing with *Nutritional Support,* the department attempts to fashion congressional authorization for the in-state store requirement from the general charge to the states, discussed above in connection with *Nutritional Support,* to establish standards and qualification criteria for Medicaid providers. It relies primarily on *Shaw v. Delta Air Lines, Inc.* (1983) 463 U.S. 85 [77 L.Ed.2d 490].)

In *Shaw*, employers in New York sought declaratory relief asserting state human rights and disability benefits laws were preempted by the Employee Retirement Income Security Act (ERISA). (463 U.S. at p. 88 [77 L.Ed.2d at p. 495].) The *Shaw* court held state employment discrimination laws not in conflict with ERISA were not preempted because federal law (Title VII of the Civil Rights Act of 1964) expressly preserves nonconflicting state laws. (*Id.* at p. 101 [77 L.Ed.2d at p. 503].)

While *Shaw* states a general principle of preemption, its facts do not present a commerce clause context and, therefore, *Shaw* does not derogate from the impact of Supreme Court decisions which require congressional authorization of discrimination against interstate commerce to be "unmistakably clear." (*Maine v. Taylor, supra*, 477 U.S. at pp. 138-139 [91 L.Ed.2d at p. 121].) In addition, state laws which discriminate against interstate commerce necessarily conflict with Congress's power to regulate such commerce. No such conflict was present in Shaw.

In *Maine v. Taylor, supra*, 477 U.S. at p. 139 [91 L.Ed.2d at p. 121], the Supreme Court looked for explicit congressional authorization in considering whether the state could prohibit importation of live baitfish. While the court generally found congressional authorization for state regulation of wildlife, it refused to infer, from that general recognition of the state's power to regulate, an authorization for the state to regulate in ways that discriminate against interstate commerce. (*Ibid.*) "Absent 'a clear expression of approval by Congress,' any relaxation in the restrictions on state power otherwise imposed by the Commerce Clause unacceptably increases 'the risk that unrepresented interests will be adversely affected by restraints on commerce.' " (*Ibid.*)

I agree with *Nutritional Support* the in-state store requirement is not authorized by the Medicaid provisions of the Social Security Act. (830 F.Supp. at p. 628.) Although

Congress instructed the states to implement a state plan providing safeguards as necessary to carry out the plan "with simplicity of administration and the best interests of the recipients" (42 U.S.C. § 1396a(a)(19)), it did not clearly express approval of regulation which discriminates against interstate commerce.

2. *Market Participant or Market Regulator*

The commerce clause does not apply to a situation in which the state is acting as participant in interstate commerce rather than a regulator. (*Reeves, Inc. v. Stake* (1980) 447 U.S. 429, 439-440 [65 L.Ed.2d 244, 252-253] (*Reeves*).) For example, in Reeves, South Dakota adopted a policy of preferential sales to state residents during periods of shortage by a cement plant owned and operated by the state. (*Id.* at pp. 431-433 [65 L.Ed.2d at pp. 247-248].) The Supreme Court upheld this policy against a commerce clause attack because the state was acting as a participant in the market rather than a regulator. (*Id.* at pp. 439-440 [65 L.Ed.2d at pp. 252-253].) It justified this conclusion by declaring "the Commerce Clause responds principally to state taxes and regulatory measures impeding free private trade in the national marketplace." (*Id.* at pp. 436-437 [65 L.Ed.2d at p. 251].)

The department claims it is a market participant rather than a market regulator with respect to Medi-Cal supplies. It contends: "California buys incontinence supplies, or at least it pays for them, in the open market for use by Medi-Cal beneficiaries." This contention mischaracterizes the state's role in providing supplies under Medi-Cal and Medicare Part B.

The assertion California "buys" medical supplies is unsupportable. There is no evidence of a contractual relationship between Del Crane and the state. The fact the state pays, at least in part, for the supplies also does not support a

finding it is a market participant. Such reasoning would make the state a participant in every market in which the state provides a subsidy to the buyer. For example, the commerce clause might not apply to agriculture because individuals who receive Aid to Families with Dependent Children use the aid to buy produce.

The department has the authority to enter into contracts for the purchase of certain medical supplies under the Medi-Cal program. (Welf. & Inst. Code, § 14105.3, subd. (b).) However, the facts of this case, specifically, lead me to the conclusion the state is not a market participant. Del Crane provides medical supplies only under Medicare Part B. Unlike purely Medi-Cal recipients, that is, those who are not Medicare Part B crossovers, the crossovers receive aid from the federal program. The state only pays the Part B premium, plus coinsurance and deductibles. The larger part of the funds comes from Medicare. Under these circumstances, the state cannot be said to be a market participant.

The in-state store requirement is a regulatory measure which "imped[es] free private trade in the national marketplace." (*Reeves, supra*, 447 U.S. at pp. 436-437 [65 L.Ed.2d at p. 251].) Indeed, its claimed purpose is to further the department's control over the market. Accordingly, it implicates the commerce clause.

3. *Economic Protectionism*

The department claims the in-state store requirement is not the kind of economic protectionist measure which violates the commerce clause. In support, it contends (1) the Legislature did not intend the statute as economic protectionism, (2) the statute is facially neutral, and (3) the statute is part of a comprehensive system to fight fraud and abuse in the Medi-Cal system. These contentions fail to validate the statute.

The purpose of the statute is not controlling in commerce clause analysis because "the evil of protectionism can reside in legislative means as well as legislative ends." (*Philadelphia v. New Jersey*(1978) 437 U.S. 617, 626 [57 L.Ed.2d 475, 483].) Thus, the legislative intent and the statute's facial neutrality are irrelevant. We must consider the practical effect of the statute. (*Nutritional Support, supra*, 830 F.Supp. at p. 628.) The practical effect of the in-state store requirement is discrimination against interstate commerce.

In arguing the in-state store requirement does not amount to economic protectionism, the department relies on precedent stating regulations having only an indirect effect on interstate commerce do not violate the commerce clause. (See *Brown-Forman Distillers v. N.Y. Liquor Auth.* (1986) 476 U.S. 573, 579 [90 L.Ed.2d 552, 559-560].) However, in-state store requirements are "extremely burdensome" on interstate commerce (*Underhill Assoc., Inc., supra,* 504 F.Supp. at p. 1152) and cannot be said to affect interstate commerce only indirectly. "When a state statute directly regulates or discriminates against interstate commerce, or when its effect is to favor in-state economic interests over out-of-state interests, we [the United States Supreme Court] have generally struck down the statute without further inquiry." (*Brown-Forman Distillers, supra,* 476 U.S. at p. 579 [90 L.Ed.2d at p. 559].)

The state could achieve its purpose, as noted in *Nutritional Support*, through other regulatory means which do not discriminate against interstate commerce so egregiously. For example, the state could require maintenance of records within the state or expeditious delivery of records to state officials. These measures would assist the department in effective auditing procedures and investigations and stem fraud and abuse.

During the hearing below and again in its briefing on appeal, Del Crane alleged it is precluded from maintaining a

store in California due to the regulations regarding payment of Medicare claims. It asserts it cannot open a store in California, and therefore bill Medicare in California, because its main office is east of the Mississippi. It would have to move the entire business to California. However, at the hearing in the trial court, Del Crane offered to reimburse the department for extra expenses incurred in supervising, auditing, and inspecting its out-of-state operation and to submit to audits and inspections without advance notice.

The department complains that whether the state could have furthered the purpose of the in-state store requirement by less burdensome means is a factual issue requiring resolution in the trial court. I disagree. As stated, the in-state store requirement is extremely burdensome. It is of the genre of discrimination "generally struck down . . . without further inquiry." (*Brown-Forman Distillers, supra,* 476 U.S. at p. 579 [90 L.Ed.2d at p. 559].)

Furthermore, despite its insistence this is a factual issue requiring resolution in the trial court, the department, in supplemental briefing, asserts: "Because . . . the essential facts of this case are undisputed, the record is sufficiently developed for this Court to make a decision . . . [¶] [A] remand for a jury trial under Code of Civil Procedure section 1090 is unnecessary."

Accordingly, I find it possible and desirable to resolve this issue. There are alternatives less burdensome than the current in-state store requirement to achieve the state's goal to stem fraud and abuse in the Medi-Cal system. The current in-state store requirement is simply a misdirected overreaction to the problems caused by the state's irresponsible use of an "honor system" for Medi-Cal claims. The state purports to stem fraud and abuse by the requirement. Instead, however, it only stems fraud and abuse by out-of-state providers by completely denying them access to the market with no indication the problems originate with those

providers, at the same time doing nothing to address in-state problems. Hence, Welfare and Institutions Code section 14125.8 and related statutes and regulations which require Medi-Cal providers to maintain a store within California violate the commerce clause of the United States Constitution.

II

Other Grounds for Del Crane's Provider Number Deactivation

The department asserts we should affirm the judgment denying a writ of mandate because, even if the in-state store requirement violates the commerce clause, there are other reasons Del Crane's provider number should remain deactivated. It claims Del Crane has refused to abide by the operational and disclosure requirements, other than the in-state store requirement, which do not violate the commerce clause.

Due to the procedural posture of this case, it is unclear whether Del Crane is eligible for provider number activation based on the valid operational and disclosure requirements. The department refused to activate Del Crane's number because it was an out-of-state provider without an in-state store. Therefore, any other requirements were not at issue. Regardless of Del Crane's cooperation, the department would have rejected activation.

Del Crane's petition for a writ of mandate requested an order directing the department to reactivate Del Crane's provider number or issue a new provider number. However, the appropriate order would be to direct the department to reconsider Del Crane's request for reactivation of its provider number or activation of a new number retroactive to the deactivation of its former number. This procedure would require Del Crane to comply with the valid statutes and

regulations, while relieving it from the unconstitutional in-state store requirement. I would reverse the judgment of the trial court and direct the court to enter judgment ordering issuance of a writ of mandate directing the department to consider reactivation of Del Crane's provider number or activation of a new number retroactive to the deactivation of the former number in a manner consistent with the commerce clause.

J. NICHOLSON

(2)

No. 94-1109

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1994

DEL CRANE MEDICAL CORPORATION,

Petitioner,

vs.

DEPARTMENT OF HEALTH SERVICES,
AN AGENCY OF THE STATE OF CALIFORNIA

Respondent.

On Petition For Writ Of Certiorari To The Court Of Appeal, Third Appellate District, State Of California

BRIEF OF RESPONDENT, DEPARTMENT OF HEALTH SERVICES, IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

DANIEL E. LUNGREN
Attorney General of the
State of California

CHARLTON HOLLAND
Assistant Attorney General

DENNIS ECKHART
Supervising Deputy Attorney
General

*RAOUL THORBOURNE
Deputy Attorney General
(CA Bar No. 72932)
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone (916) 324-2884

Attorneys for Respondent

*Counsel of Record

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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QUESTIONS PRESENTED

1. Whether this Court is without jurisdiction to hear the two questions presented for resolution by petitioner (Petition, p. i) since these questions were not raised and/or were not decided below.

2. Whether, under the federal Medicaid system, the State of California may establish minimum standards and qualifications for providers of services to program beneficiaries.

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No. 94-1109

In The

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DEL CRANE MEDICAL CORPORATION,

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Respondent.

On Petition For Writ Of Certiorari To The Court Of Appeal, Third Appellate District, State Of California

BRIEF OF RESPONDENT, DEPARTMENT OF HEALTH SERVICES, IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

STATUTORY AND CONSTITUTIONAL PROVISIONS

42 United States Code section 1396a(a)(22) ("A State plan for medical assistance must . . . include descriptions of . . . (D) other standards and methods that the State will use to assure that . . . services provided to recipients of medical assistance are of high quality. . . . ");

42 United States Code section 1396a(a)(30)(A) ("A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and payment for, care and services available under the

plan . . . to assure that payments are consistent with efficiency, economy, and quality of care. . . . ")

SUPPLEMENTAL STATEMENT OF THE CASE

A. BACKGROUND:

Pursuant to Rule 15.1, the Department of Health Services (hereinafter "the department") supplements Del Crane's statement of the case to point out omissions and inaccuracies.

Initially, it is noted that, contrary to petitioner's contention, this case is *not* about any attempts by the State of California to refuse to reimburse petitioner as provided by federal law. (Petition, pp. 6-10.) The sole issue in this case, and the sole issue decided below, was whether the department could lawfully de-activate petitioner's Medi-Cal[1] provider number given the undisputed fact that petitioner failed and refused to comply with the Medi-Cal operational and disclosure requirements for providers of incontinence supplies contained in California Welfare and Institutions Code sections 14125 et seq. (Appendix A hereto.) The decision below did not reach the reimbursement issue petitioner raises herein since no purpose would have been served in deciding the correct amount

[1] In this brief references to "Medi-Cal" are to the Medicaid Program in California and references to Medicaid are references to the Medicaid Program in general as applicable to other states or to the federal laws and regulations which apply. Unless otherwise noted, any reference to Medicaid is fully applicable to Medi-Cal.

petitioner may be owed if the latter is lawfully barred from participating in the Medi-Cal program as a provider in the first place.

The trial court denied Del Crane's petition for Writ of Mandate to reinstate its Medi-Cal provider number, ruling that petitioner had not demonstrated that the department's rescission of its provider number, on the basis of Del Crane's refusal to comply with the state's regulations, violated any state or federal law or regulation. The California Court of Appeal affirmed. (Petition, Appendix B.)

In upholding the trial court's judgment, the Court of Appeal declined to reach petitioner's constitutional challenge to one of the operational requirements set forth in Welfare and Institutions Code section 14125, namely, that providers of incontinence supplies maintain an office or business location in California. The Court of Appeal concluded that petitioner had failed to show good cause for waiting until its reply brief in that court to raise for the first time the Commerce Clause argument regarding this requirement, and added that consideration of that issue was particularly inappropriate in this case because critical factual questions remained to be adjudicated. (Petition, Appendix B, p. 15a.) And, given its agreement with the trial court that the department was authorized to deactivate petitioner's provider number because of petitioner's refusal to comply with any of the relevant Medi-Cal regulations, the Court of Appeal did not reach the Medicare reimbursement issues either.

The California Supreme Court summarily denied review, also without reaching either the Commerce

Clause or the Medicare reimbursement issues petitioner raises herein. (Petition, Appendix A.)

B. FACTS:

This case involves California's administration of the Medi-Cal program with respect to providers of incontinence medical supplies. In this context, incontinence medical supplies include disposable medical supplies such as diapers, absorbent pads, and the like. The California Legislature has devoted a considerable amount of attention to providers of incontinence medical supplies. Special rules apply to participation by these providers.

Effective July 31, 1990, the Legislature substantially amended the Medi-Cal program in the area of participation by providers of incontinence medical supplies. Sections 14125 and 14125.1 through 14125.9 were added to the California Welfare and Institutions Code to stringently regulate this class of providers. (Appendix A.) Additional provisions were added, effective January 1, 1992, which further strengthened regulation of these providers. (See Appendix A, § 14125.2.)

Subdivision (b) of section 14125.2 requires all Medi-Cal providers of incontinence supplies to establish a place of business in California which is readily identifiable as a medical supply business, that the place be open to the public at regularly established business hours, have incontinence supplies in stock or immediately available, and meet all local laws and ordinances regarding business licenses and operations. Additionally, as a condition of continued participation in the Medi-Cal program, business entities providing incontinence medical

supplies would henceforth have to provide the department with the name of the corporation, the official titles of all applicants, and a list of all the corporate officers as well as the California driver's license or California identification card number of all applicants, co-owners, corporate officers and financially interested parties. Providers would also henceforth be required to provide to the department their California business permit control number issued by the State Board of Equalization for the business location from which they rendered services to the public, a statement of all sources of capital, identity of all investors, disclosure of all manufacturers, suppliers and providers doing business with the provider, and disclosure of all entities to whom the provider has extended a line of credit. Welf. & Inst. Code § 14125.8, subds. (a)(1) through (5); Petition, Appendix B, p. 6a.

Because of these new operational and disclosure requirements, all provider numbers for suppliers of durable medical equipment, a category which includes incontinence supplies, were deactivated pending receipt of the newly-required information. Re-enrollment of out-of-state providers, such as petitioner, was permitted only for the provision of supplies on an emergency basis when Medi-Cal beneficiaries were traveling in the provider's home state. (Petition, Appendix B, p. 7a.)

The reasons for these changes are evident from the implementing legislation. In enacting this legislation, the Legislature was attempting to curtail fraud and to reduce the excessive fees that some providers, particularly out-of-state providers, had been charging for these items. (Petition, Appendix B, pp. 5a-6a.)

Following the enactment of the 1990 legislation and the deactivation of the Medi-Cal provider numbers, the department mailed out packets to all providers advising them of the new operational and reporting requirements. The packet included application forms which the providers were required to satisfactorily complete and return to the department before their provider numbers could be re-activated.

In addition to the aforementioned packet, the department also notified out-of-state providers, including petitioner, that Medi-Cal would henceforth reimburse them only for emergency services provided to Medi-Cal beneficiaries traveling in the provider's home state.

C. PETITIONER'S RESPONSE TO THE 1990 LEGISLATION:

The department temporarily deactivated petitioner's number on May 18, 1990, even before the effective date of the 1990 legislation, because the amount of Medi-Cal payments made to petitioner in the preceding year appeared excessive for an out-of-state provider and raised concerns within the department. Although the department later reinstated petitioner's number, on July 26, 1991, petitioner's provider number was deactivated again, retroactive to June 1, 1990, when an audit revealed that the over $327,000.00 the department had paid petitioner during the preceding year represented reimbursement for incontinence supplies to Medi-Cal beneficiaries

who were residents of long-term care facilities located in California. These payments were clearly inconsistent with the 1990 legislation which limited Medi-Cal reimbursement for out-of-state incontinence suppliers to situations when California beneficiaries were travelling in the provider's home state. Additionally, these payments to petitioner were improper because effective January 1, 1991, the newly calculated per capita reimbursement rate for these beneficiaries included an augmentation for various items, including incontinence supplies. Accordingly, providers, such as petitioner, could no longer separately bill Medi-Cal for incontinence supplies. Significantly, petitioner does not dispute any of the foregoing facts. (Petition, Appendix B, pp. 6a-7a.)

For these reasons, and because petitioner has since steadfastly refused to comply with any of the new operational and reporting requirements contained in section 14125, i.e., it did not establish a business location in California and failed to complete and return the re-enrollment packet requesting the newly-required information, its provider number remains deactivated. (Petition, Appendix B, p. 7a.)

SUMMARY OF ARGUMENT

This Court is without jurisdiction to hear either of the questions petitioner raises in this appeal. First, petitioner waived its right to have this Court rule on the Commerce Clause issue by failing to timely raise it below. Second, although petitioner did properly raise the Medicare Part

B reimbursement issue before the state courts, the California Court of Appeal based its decision on other grounds and expressly declined to reach the reimbursement issue. In the absence of a final state judgment or ruling on either of these issues, this Court should deny the petition for failure to comply with the requirements of Supreme Court Rule 14.1(h).[2]

The decision below actually concerned the authority of the California Department of Health Services to establish and enforce minimum qualifications for entities wishing to provide services to Medi-Cal program beneficiaries. In this regard, it is well established that under the Medicaid system states are not only authorized, but they are in fact *required* to establish minimum qualifications for providers of services under the program in order to insure that patient care standards are maintained. 42 U.S.C. § 1396a(a)(22) and 42 U.S.C. § 1396a(a)(30)(A); *Schweiker v. Hogan*, 457 U.S. 569,

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[2] Rule 14.1(h) provides in pertinent part that:
"(h) If review of a judgment of a state court is sought, the statement of the case shall also specify the stage in the proceedings, both in the court of first instance and in the appellate courts, at which the federal questions sought to be reviewed were raised; the method or manner of raising them and the way in which they were passed upon by those courts; and such pertinent quotation of specific portions of the record or summary thereof, with specific reference to the places in the record where the matter appears (*e.g.*, ruling on exception, portion of court's charge and exception thereto, assignment of errors) as will show that the federal question was timely and properly raised so as to give this Court jurisdiction to review the judgment on a writ of certiorari. . . . "

589-591 (1982); *Harris v. McRae*, 448 U.S. 297, 301 (1980). Therefore, as a provider of incontinence supplies to Medi-Cal beneficiaries, petitioner is required to comply with the state's regulations regarding the minimum qualifications for such providers. Petitioner's undisputed refusal to so comply authorized the department to deactivate its Medi-Cal provider number. The decision below rejecting petitioner's contention that it is not subject to California's regulatory authority, (notwithstanding the fact it seeks Medi-Cal reimbursement for services provided to Medi-Cal beneficiaries), was therefore proper and should remain undisturbed.

ARGUMENT

I.

THE PETITION SHOULD BE DENIED INASMUCH AS THERE IS NO FINAL STATE COURT JUDGMENT OR RULING REGARDING EITHER OF THE QUESTIONS PETITIONER PRESENTS FOR RESOLUTION HEREIN

This Court has jurisdiction to hear appeals from state court judgments only when a federal question is involved. 28 U.S.C. § 1257 subdivision (a). However, before this Court may entertain such an appeal, Supreme Court Rule 14.1(h) requires the petitioner to state:

> " . . . the stage in the proceedings, both in the court of first instance and in the appellate courts, at which the federal questions sought to be reviewed were raised; the method or manner of raising them *and the way in which they were passed upon by those courts*. . . . " (Emphasis added.)

In interpreting these requirements, this Court has held that petitioners have the burden of establishing that the federal question was timely and properly raised in the state court proceeding. *Godchaux Co. v. Estopinal*, 251 U.S. 179, 181 (1919); *Beck v. Washington*, 369 U.S. 541, 550-554 (1962). A failure to observe state procedural rules for the raising of constitutional questions requires dismissal of the petition. *In re Lamkin*, 355 U.S. 59 (1957). Finally, this Court has also held that the federal claim must have both been raised *and decided* by the state court. *Whitney v. California*, 274 U.S. 357, 360 (1927). Thus, this Court has declined to exercise jurisdiction in situations where the highest state court expressly refuses to decide the federal question because of petitioner's failure to comply with the state procedural requirements for raising such questions. *Pennsylvania R. Co. v. Illinois Brick Co.*, 297 U.S. 447, 462-463 (1936).

In the instant case, it is undisputed that petitioner did not raise the Commerce Clause issue regarding the in-state office requirement before the trial court. In fact, petitioner did not even raise the issue in its opening brief to the California Court of Appeal. Not until the filing of its reply brief with that court did the Commerce Clause issue first surface. In these circumstances, the California Court of Appeal specifically, and properly, declined to hear petitioner's Commerce Clause argument, invoking the long-recognized California rule of appellate practice that arguments raised for the first time in a reply brief will not be entertained absent a showing, not made by petitioner, that its failure to timely present the issue before was justified. (Petition, Appendix B, pp. 14a-15a.) The California Supreme Court summarily denied review

also without deciding the Commerce Clause issue. (Petition, Appendix A, p. 1a.)

Thus, the Commerce Clause issue relative to the in-state office requirement was expressly not decided below. This means that a critical requirement for the exercise of this Court's jurisdiction under Rule 14.1(h), i.e., a final state court decision on the merits of the Commerce Clause issue, is missing. By not timely raising it before the California courts, petitioner is deemed to have waived its right to raise the Commerce Clause issue before this Court. *Bailey v. Anderson*, 326 U.S. 203, 206-207 (1945); *Herndon v. Georgia*, 295 U.S. 441, 443 (1935). There being no basis for this Court to take jurisdiction over that issue, the petition must be denied as to petitioner's Question No. 1.[3]

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[3] However, any decision by this Court first to grant review and then to strike down the in-state office requirement as unconstitutional would not lead to a different result herein since it is undisputed that petitioner has not complied with any of the operational and disclosure requirements provided in the 1990 legislation.

As set forth in more detail above, Welfare & Institutions section 14125 et seq. established a set of new operational and disclosure requirements for suppliers of incontinence supplies of which the in-state office requirement is only one. Petitioner has never contended that any of these other requirements violates the Commerce Clause. That petitioner has not complied with any of these requirements is not subject to dispute, given its contention that it is not subject to California's regulatory authority and is completely exempt from complying with any Medi-Cal regulations. (See Argument section II, *infra*.) Since the decision below correctly held that the state's regulations were lawful, the department's refusal to activate petitioner's Medi-Cal provider number, so long as the latter refuses to comply

The same result ensues regarding the Medicare Part B reimbursement issue. (Petition, p. i.) Although petitioner did timely raise that issue before the California Court of Appeal, that court expressly declined to reach it in view of the fact it affirmed the trial court's ruling on other grounds, i.e., that as a provider of incontinence supplies to Medi-Cal program beneficiaries, petitioner was fully subject to California's regulatory authority, and its failure and refusal to comply with the state-established minimum qualifications for providers of incontinence supplies authorized the department to deactivate petitioner's provider number. (Petition, Appendix B, pp. 11a-13a.) There is, therefore, no final state court ruling on the reimbursement issue either. In these circumstances, the petition must be dismissed in its entirety since there is no basis for this Court to hear Question No. 2 either. *Whitney*, 274 U.S. at 360.

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with any of them, (not just the in-state office requirement), is proper. Thus, the department would still have a lawful basis upon which to continue to deny petitioner a Medi-Cal provider number, without regard to how the issue of the constitutionality of the in-state requirement is ultimately resolved. Consideration of that question, in the circumstances presented herein, would amount to nothing more than an academic exercise since the ultimate result would be unaffected. The department would still prevail. This is yet another reason the decision below was correct and why review by this Court is not warranted.

II.

ASSUMING THE ISSUE OF CALIFORNIA'S AUTHORITY TO REGULATE THE CONDITIONS UNDER WHICH PETITIONER WILL BE PERMITTED TO BECOME A MEDI-CAL PROVIDER IS PROPERLY BEFORE THIS COURT, THE DECISION BELOW WAS PROPER SINCE PETITIONER IS SUBJECT TO CALIFORNIA'S REGULATORY AUTHORITY, AND IT IS UNDISPUTED THAT PETITIONER HAS FAILED AND REFUSED TO COMPLY WITH ANY OF THE STATE'S REGULATIONS

The only federal question that is arguably properly before this Court is whether federal Medicaid law authorizes the State of California to establish minimum standards that prospective providers of incontinence supplies must satisfy in order to participate in the program.[4] The answer to this question is clearly "yes."

It is well settled that, under Medicaid, states enjoy a considerable amount of discretion in determining the amount and scope of the services they will provide and/or pay for. *Schweiker*, 457 U.S. at 589-91. Also not subject

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[4] As noted, this issue is not directly raised in the petition. This Court could, therefore, completely ignore it and dismiss the petition on the basis of the arguments presented in the preceding section regarding the issues that are squarely raised by the petition. Nonetheless, it is arguable that the issue of the nature and extent of the state's regulatory authority under Medicaid is indeed before this Court since it formed the basis of the decision below, it does involve a federal question, and the issue is addressed, if only briefly, in the petition. For these reasons, respondent will proceed to discuss this issue in this section. (See Supreme Court Rule 14.1(a); see also *Blum v. Bacon*, 457 U.S. 132, 137 n. 5 (1982) ("respondent may rely on any matter appearing in the record in support of the judgment below."))

to dispute is the fact that, with regard to Medicaid provider qualifications, federal law not only authorizes states to establish minimum standards for the participation of these entities in their respective programs, it *requires* states to establish such criteria in order to obtain approval of the state plan by the federal Medicaid agency. See also 42 U.S.C. § 1396a(a)(22) and 42 U.S.C. § 1396a(a)(30)(A). Thus, the California Court of Appeal correctly concluded that the department was clearly authorized to establish the requirements set forth in Welfare and Institutions Code section 14125 et seq. governing providers of incontinence supplies and that, given petitioner's failure to comply with these regulations, the deactivation of its Medi-Cal provider number was proper. (Petition, Appendix B, pp. 12a-13a.)

Petitioner argues that it need not comply with these regulations. It states that while it is not contending that California may not "exert proper supervision" over suppliers to the Medi-Cal program, it does not "wish" to be such a supplier, "wishing" instead "to continue to provide [supplies] only to Medicare [beneficiaries] and to have DHS fulfil (sic) its separate obligation to make copayments on behalf of appropriate patients." (Petition, p. 9.) This is a modified version of petitioner's primary arguments below, namely, that because the Medicare Part B beneficiaries it supplies are Medicare, rather than Medi-Cal, beneficiaries, petitioner is beyond the reach of California's regulatory authority, notwithstanding the fact it seeks Medi-Cal reimbursement for products used by these same beneficiaries. The bottom line, as the Court of

Appeal correctly put it, is that petitioner believes California should simply pay, "no questions asked." (Petition, Appendix B, p. 11a.)

The appellate court, however, correctly rejected petitioner's contentions in this regard. Citing *Samuel v. California Department of Health Services*, 570 F. Supp. 566 (N.D. Cal. 1983), the Court of Appeal noted that Medicare Part B coverage is included in a recipient's Medi-Cal benefits package[5] and agreed with the department's contention that this inclusion means that these crossover beneficiaries must be considered Medi-Cal patients whose care is subject to California's laws and regulations. (Petition, Appendix B, p. 5a; see *Samuel* 570 F. Supp. at p. 573.) The court below further stated that the state plan, specifically approved by the federal Department of Health and Human Services, explicitly provides for state regulation

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[5] It bears noting that the only reason why Medicare is implicated in this action is because Medi-Cal regulations require that its program beneficiaries apply for Medicare benefits as well if they qualify. Tit. 22, Cal. Code Regs. § 50777; (see Appendix B hereto). The fact that once enrolled in Medicare, California pays the Part B premium and co-payments on behalf of these individuals in no way diminishes their status as Medi-Cal beneficiaries. These crossover beneficiaries enter the system as Medi-Cal beneficiaries and remain as such throughout. *Samuel*, 570 F. Supp. at 573. Medi-Cal's requirement that these persons enroll in Medicare is simply a method through which the state is able to shift some of the cost of the services provided to the federal government. It should be noted further that section 50773 of title 22 of the California Code of Regulations (see Appendix C hereto), explicitly provides that these premium payments under the "buy-in" agreement are made on behalf of *Medi-Cal* beneficiaries.

of entities providing services to Medicare Part B beneficiaries. (Petition, Appendix B, p. 12a; see also 42 U.S.C. § 1396a(a)(22) and 42 U.S.C. § 1396a(a)(30)(A) which, inter alia, require the states to establish minimum standards relating to the quality of services and standards of care for Medicaid beneficiaries.)

In upholding the trial court's conclusion that petitioner was subject to California's regulations, the California Court of Appeal correctly viewed it as almost inconceivable that the state would be required to reimburse providers such as petitioner while at the same time being precluded from having any say over the qualifications of these providers or the products and services these entities provide. The court stated:

> "Medicare and Medicaid are designed to coexist. Common sense dictates that government must take responsibility for funds it expends on social programs." (Petition, Appendix B, p. 12a.)

Thus, petitioner's "wishes" with regard to its provider status and its apparent "concession" that California may "supervise," but presumably not "regulate," its participation in the Medi-Cal program are irrelevant and entirely beside the point.[6] State and federal law make it abundantly clear that petitioner is a Medi-Cal provider and that it is fully subject to this state's regulatory authority. As the Court of Appeal concluded:

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[6] Petitioner never explains what it means by its use of the term "supervision" in this context. Nor does it cite any authority for the peculiar proposition that states may "supervise," but not regulate, providers of services to cross-over beneficiaries.

> "Del Crane is a provider of incontinence medical supplies seeking to receive payments from Medi-Cal fund, and California has regulations . . . concerning such providers. Del Crane's contention there was no authority for the state to deactivate the Medi-Cal provider number is without merit." (Petition, Appendix B, p. 13a.)

As it did below, petitioner again cites *New York City Health and Hospitals Corporation v. Perales*, 954 F. 2d 854 (2nd Cir. 1992) in support of its contention that crossover beneficiaries are Medicare beneficiaries. (Petition, p. 7.) Petitioner also cites *Perales* for the proposition that states are required to reimburse providers the full 20% of the cost of the products or services they provide which is not paid by Medicare under Part B. However, as noted above, and as the Court of Appeal found, the specific amount petitioner is owed by Medi-Cal is not the issue in this proceeding. The question here is simply whether petitioner must comply with Medi-Cal's regulations. *Perales* is of no help to petitioner in this regard since the state of New York's authority to regulate the provider involved in that case was not addressed by the Second Circuit because it was not at issue. (See Petition, Appendix B, p. 11a.) Thus, petitioner's reliance on *Perales* is misplaced.[7] Moreover, the court below noted that a different federal court, the dissenting justice in *Perales*, as well as the

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[7] Also beside the point and irrelevant for these same reasons is petitioner's argument that subsequent legislation has allegedly superseded the conclusions regarding the reimbursement issue reached by the court in *Samuel*. (Petition, pp. 9-10.)

federal Medicaid Agency have all concluded that cross-over beneficiaries are Medicaid beneficiaries. (Petition, Appendix B, pages 9a-11a.)

Thus, petitioner's argument that the holding below must yield to contrary (and higher) federal authority under the Supremacy Clause of the United States Constitution (petition, p. 10) is without merit. The Supremacy Clause to the United States Constitution is not implicated here. As both the trial court and the Court of Appeal noted, petitioner failed to establish that California Welfare and Institutions Code section 14125 et seq. violate any state or federal law. (Petition, Appendix B, p. 12a.) To the contrary, the decision below is fully consistent with the Medicaid scheme established by Congress, which, as noted, clearly authorizes states to regulate providers.

CONCLUSION

The decision below did not reach either of the questions presented for resolution in the instant petition. There being no final state court judgment or decision regarding the merits of either question, the petition must be denied under Rule 14.1(h). To the extent the issue of the State of California's authority to establish and enforce minimum participation standards for providers of services to Medi-Cal beneficiaries is properly before this Court, the decision below upholding such authority was based on well-settled law regarding the powers delegated by Congress to the states under the Medicaid statutory scheme. Since it is fully consistent with federal law in this

regard, no scrutiny of the decision below by this Court is warranted.

For these reasons, the petition should be denied.

Dated: February 21, 1995

Respectfully submitted,

DANIEL E. LUNGREN
Attorney General of the
State of California

CHARLTON HOLLAND
Assistant Attorney General

DENNIS ECKHART
Supervising Deputy Attorney
General

*RAOUL THORBOURNE
Deputy Attorney General
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone (916) 324-2884

Attorneys for Respondent

*Counsel of Record

APPENDIX A

California Welfare and Institutions Code
Section 14125 et seq.

Article 3.7

INCONTINENCE MEDICAL SUPPLIES

§ 14125. Purpose of article; reimbursement

The purpose of this article is to establish provider reimbursement rates for incontinence medical supplies covered by the Medi-Cal program. Reimbursement for incontinence medical supplies shall consist of the weighted average of the negotiated contract prices within each product category * * * , plus a markup fee equal to 40 percent of the resulting adjusted contract price.

§ 14125.1 Definitions

Unless the context requires otherwise, the definitions set forth in this section shall govern the construction and meaning of the terms and phrases used in this article.

(a) "Incontinence medical supplies" means disposable medical supplies that are covered benefits under the Medi-Cal program pursuant to subdivision (s) of Section 14132 when prescribed by a physician for the treatment of individuals who are incontinent. Incontinence medical supplies include, but are not limited to disposable diapers, briefs, underpads, undergarments, liners or pads, pant and pad systems, and skin care products.

(b) "Department" means the State Department of Health Services.

* * *

(c) "Manufacturer" means any person, partnership, or corporation who assembles or combines the components of incontinence supplies into a final product sold to dealers.

(d) "Principal labeler" means any person, partnership, or corporation who purchases from a manufacturer an assembled product which is sold to dealers under the principal labeler's label.

(e) "Dealer" means any person, partnership, corporation, or other entity that is recognized by the manufacturer or principal labeler as a provider or retail outlet for its line of incontinence medical supplies, and which provide these supplies directly to consumers. The term "dealer" includes a retailer.

§ 14125.2 Product and provider qualification; "product" and "general retail distribution" defined

(a)(1) To qualify for Medi-Cal coverage a product shall be in general distribution, sold to the general public, and comply with any standards for products established by law or regulation. No product that is manufactured, distributed, or otherwise promoted for the exclusive use of beneficiaries of the Medi-Cal program shall be a Medi-Cal benefit.

(2) For the purposes of this section, "product" means any product which is in general retail distribution.

(3) For purposes of this subdivision, "general retail distribution" means either of the following:

(A) The product is included in a listing of approved products for purchase either by the federal or state government.

(B) The product is on display and available for purchase by customers for private payment at retail outlets which are open to the general public.

(b) In order to qualify as a Medi-Cal provider of incontinence medical supplies, a dealer shall have an established place of business that is readily identifiable as a medical supply business, be open to the general public at regularly established business hours, have incontinence supplies in stock on the premises or in a warehouse under the provider's direct control, and meet all local laws and ordinances regarding business licensing and operations. The department shall establish additional rules and regulations for participation in the Medi-Cal program as it deems necessary to ensure adequate safeguards to the integrity of the Medi-Cal program.

§ 14125.3 Contract prices; reduction of weighted average of negotiated prices; premium underpads; other products

The department shall reduce the weighted average of the negotiated contract prices within each product category in effect on June 30, 1992, as follows:

(a) For all premium underpads, as defined by the department, by 24 percent.

(b) For all other incontinence medical supply products, as defined by the department, by 14 percent.

§ 14125.4. Utilization controls; expenditure limits for incontinence medical supplies; amount; adjustment; exemptions

(a) No later than January 1, 1994, the department shall establish utilization controls that limit expenditures for incontinence medical supplies per beneficiary to no more than one hundred sixty-five dollars ($165) per month. Incontinence creams and washes shall be excluded from this limitation. The expenditure limit established by this section may be adjusted in the annual Budget Act to reflect changes in wholesale prices. These utilization controls shall be published in provider bulletins.

(b) The department shall, by prior authorization, allow a beneficiary to exceed the utilization limits established by this section when justified to the department's satisfaction not later than January 1, 1994.

(c) Notwithstanding any other provision of law, no regulations shall be necessary to define the incontinence medical supplies subject to the reductions required in Section 14125.3, or to establish and implement the utilization controls required in this section.

* * *

§ 14125.8. Provider disclosures; claim submission; provider number issuance moratorium

(a) In order to more fully identify the owner or owners of companies or corporations that apply to be or currently are providers of incontinence medical supplies,

within 30 days of the receipt of a request from the department, or a request to the department from the Department of Justice, the applicant or provider shall provide, as part of the application process or as a condition of continued participation in the Medi-Cal program, the following:

(1) The name of the corporation, the official titles of the applicants, and a list of all the corporate officers.

(2) The California driver's license or California identification card number of the applicants, coowners, corporate officers, and financially interest parties.

(3) The applicant's business permit control number, issued by the State Board of Equalization, for the business location where services are rendered to the public.

(4) A statement of all current sources of capital, identity of all investors, disclosure of all manufacturers, suppliers, and providers currently doing business with the applicant, and disclosure of all entities to whom the applicant has extended a line of credit.

(5) A statement certifying that all information supplied pursuant to this section is accurate.

(b) A Medi-Cal provider of incontinence supplies shall not submit a claim for goods or services to the department prior to the date the goods or services are delivered to the Medi-Cal beneficiary. The date of delivery to a beneficiary shall be the earlier of the date the beneficiary actually received the goods or services, or the date the goods were posted or otherwise dispatched from the provider's premises and control. A claim submitted to the department prior to the date of delivery shall not be

paid. Violation of this subdivision shall be grounds for expulsion from the Medi-Cal program.

(c) The department may implement a 180-day moratorium on the issuance of new provider numbers for incontinence medical supply dealers when the department determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program.

§ 14125.9. Incontinence supplies contracts pursuant to § 14105.3

Nothing in this section shall be interpreted as limiting or interfering in any way with the department's authority to contract for the provision of incontinence medical supplies pursuant to subdivision (b) of Section 14105.3.

APPENDIX B

Title 22, California Code of Regulations Section 50777

§ 50777. Requirement to Apply for Medicare.

(a) The following Medi-Cal applicants and beneficiaries shall be required to apply for Medicare Part A:

(1) Any person 64 years and 9 months of age or older.

(2) Persons applying for Medi-Cal on the basis of blindness or disability.

(3) Persons who are receiving disability payments under title II of the Social Security Act or Railroad Retirement program unless the county can obtain verification of receipt of Social Security title II disability payments in accordance with section 50167. In these instances Medicare enrollment is deemed to be automatic beginning with the 25th month of receipt of this benefit and application is not required.

(4) Persons receiving dialysis-related health care services.

(b) The following Medi-Cal applicants and beneficiaries shall be required to apply for Medicare Part B:

(1) Persons who are applying for Medi-Cal on the basis of being aged.

(2) Persons applying for Medi-Cal on the basis of blindness or disability unless the county can obtain verification of receipt of Social Security Title II disability payments in accordance with section 5167 [sic]. In these instances Medicare enrollment is deemed to be automatic beginning with the 25th month of receipt of this benefit and application is not required.

(3) persons receiving dialysis-related health care services, unless the county can obtain verification of receipt of Medicare Part A benefits in accordance with section 50167. In these instances, Medicare Part B enrollment is deemed to be automatic and application is not required.

(c) The persons specified in (a) and (b) shall submit verification to the county department of the approval or denial of their Medicare eligibility within 60 days of the day they are notified or the requirement to apply or within 10 days of the notification of approval or denial if their eligibility for Medicare is not determined within 60 days. Except for those persons applying under Sections 50258 and 50256, persons who would only be eligible for Medicare Part A if they paid a premium shall not be required to accept Part A benefits.

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APPENDIX C

Title 22, California Code of Regulations Section 50773

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§ 50773. Medicare Buy-In.

(a) Medicare Buy-In is the payment of Medicare Part B premiums by the Department under the California Medicare Buy-In agreement with the Social Security Administration for Medi-Cal beneficiaries who are:

(1) Eligible under the SSI/SSP. Other PA or MN program on the basis of age.

(2) Eligible under the SSI/SSP, Other PA or MN program on the basis of blindness or disability and also eligible for Medicare Part B in accordance with section 50775(a).

(b) State payment of Part B premiums under the Buy-In provisions shall become effective the:

(1) Second month after the month in which Medi-Cal eligibility is approved for MN persons who were not eligible for a federally covered Medi-Cal program in the month before their first month of MN eligibility.

(2) First month of eligibility for PA and Other PA recipients and MN persons not specified in (1).

(3) The first month after the month of eligibility for qualified Medicare beneficiaries in accordance with Section 50258.

(4) The first month eligibility is approved for Specified Low-Income.